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FTR

March 1, 2011

The Honorable Joseph J. Crisco and Robert W. Megna, Co-Chairs and Members
Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06016

RE: Raised Bill 1084: An Act Concerning Out-of-Pocket Expenses for Non-preferred Brand Name Drugs

Dear Senator Crisco, Representative Megna, and Members of the Insurance and Real Estate Committee:

The Arthritis Foundation is concerned about the negative effects of high co-payments or co-insurance for specialty tiers in commercial health insurance policies on access to newer biologic therapies that have proven to reduce disability.

For people with inflammatory forms of arthritis, such as rheumatoid or psoriatic arthritis, newer biologic therapies have in repeated studies shown that they prevent joint destruction and related disability[1] The cost of these newer biologic therapies ranges from $15-40,000 per year.

What has happened over the past several years is that instead of the traditional three-tier drug formulary (Tier1=generics, Tier 2=preferred brand name drug; Tier 3-non-preferred brand name drug), plans have begun to add a fourth and even a fifth "specialty" tier, which usually have a co-insurance or cost-sharing percentage rather than a fixed co-pay. These cost-sharing percentages can range from 25-50% of the cost of the specialty medication.

For instance, my eldest son has psoriatic arthritis. He is a high school athletic director and physical education teacher. He is on one of the most widely prescribed self-injected medication used for inflammatory types of arthritis. A 25% co-insurance would be equivalent to approximately $6,000 or 12% of his annual salary. He would not be able to afford this level of out-of-pocket payment.

Goldman and colleagues completed a study that analyzed the change in members' utilization given a change in their cost-sharing for specialty drugs, including rheumatoid arthritis. The study included pharmacy and medical claims from 55 health plans offered by 15 large employers with 1.5 million beneficiaries in 2003 and 2004. The study showed that doubling the co-pay (which is a fixed amount much less than co-insurance) resulted in a 21% reduction in use among people with rheumatoid arthritis[2]. An earlier study by the same authors concluded that high cost sharing delays the initiation of drug therapy for patients newly diagnosed with chronic disease[3]. In rheumatoid arthritis, studies show that most of the joint damage occurs in first three years of disease, so any delay increases the risk for lifelong disability.

The state of Maryland issued a report in 2010 on a proposal that would regulate specialty tiers. The report concluded that in the absence of separate out-of-pocket limits, state residents would have a significant issue purchasing specialty medications[4].

Last year, New York was the first state to pass legislation regulating specialty tiers. In 2011, California, Maryland, Massachusetts and Vermont are considering similar legislation. Some bills prohibit specialty tiers and others use various approaches to reduce the annual out-of-pocket limit.

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The Arthritis Foundation recommends that your committee consider the approach that the New York Assembly took last year when they passed similar legislation on specialty tiers. If an insurance company creates a specialty tier then the **co-pay and co-insurance total should not exceed the co-pay and co-insurance for non-preferred brand name drugs on the third tier**.

I am unable to testify before your Committee today because I am in Washington DC with our volunteer advocates but I hope your committee will address our concerns.

Sincerely,

Paula M. Haney, RPT
Chair, Public Policy Committee
PO Box 104
160 Machine Shop Hill Road
South Windham, CT 06266

[1] Saag Kg, Teng GC, Patkar NM et al: American College of Rheumatology 2008 recommendations for the use of non-biologic and biologic disease-modifying anti-rheumatic drugs in rheumatoid arthritis. *ArthRheum* 2008:59:762-784.

[2] Goldman DP et al: Benefit design and specialty drug use. *Health Affairs.* 25:1319

[3] Solomon MD, Goldman DP, Joyce GF, Escarce JJ: Cost sharing and the initiation of drug therapy for the chronically ill. *Arch Int Med.* 169:737-739, 2009

[4] Welch J, Bender K, Kerr D, Fitzpatrick R: Annual mandated health insurance services evaluation. Maryland Health Care Commission, January 20,2011.